**Testimony of New Jersey Child Advocate Kevin M. Ryan**
**Before the Senate Health Committee**
**Monday, September 26, 2005**

Thank you Chairman Vitale and Senators for the opportunity to be with you today to discuss the development of the children's mental health system in New Jersey, and particularly the closure of the Arthur Brisbane Child Treatment Center.

As you know, the Office of the Child Advocate is an independent public agency charged "to ensure the provision of effective, appropriate and timely services for children at risk of abuse and neglect in the State."

I am here today to provide you with information from our monitoring of the planned closure of Brisbane and the state's development of new alternative programs and services for children and youth. The Department of Human Services is preparing to roll out the largest expansion of children's mental health placements in recent memory, and this development provides opportunities to better serve thousands of children and youth.

Last year we concluded a review of conditions for children at Brisbane, and evaluated how those conditions were impacted by the children's mental health system at large. We observed that many of the children at Brisbane during our investigation were cycling and recycling through this system without establishing long-term wellness. Brisbane's deficiencies were symptomatic of the overall system of care, which we recommended be overhauled and expanded.

We have continued to monitor the conditions of care at Brisbane and plan to do so throughout the next several months. In our last site inspection this summer we found:

- The youngest residents and children from detention and secure correctional settings no longer receive care at Brisbane because of alternative sites that have been established. As a result, the Brisbane census is significantly down, and it has not exceeded its ceiling of 40 children this year.

- Most of Brisbane's previously-identified physical plant, suicide, health and safety risks have been remediated. However, several structures on the campus are so dilapidated that the Department of Human Services was unable to improve them without a major capital investment, and the children have been removed from those buildings.

Several weeks ago, Deputy Commissioner Kathi Way briefed me on DHS' plans to expand a new array of hospital, residential, and family settings to serve children

with the most complex and serious mental health needs. The Department's challenges to erect this continuum were significant, and their efforts to achieve the largest deployment of children's mental health placements have also been significant. It is my understanding that DHS intends to expand the continuum by 259 residential placements by December 30, 2005. As of this afternoon, 85 of those beds are open for children in New Jersey.

As the children's mental health system expands with new services, I believe there are several critical areas for your consideration today, and for the discussion over the coming weeks.

1. **No Warehouses.** We need to ensure that children do not languish in hospital or residential settings, regardless of whether they are private or public. In the past, the lack of step-down services has contributed to the warehousing of children in facilities all across New Jersey, including Brisbane. I know from my investigations into the juvenile detention centers and Brisbane that children who have been deemed ready for discharge have been waylaid because of our limited capacity to provide residential programs and intensive, outpatient supports in these children's own communities.

   Clinical research has shown that children make the most progress when they receive treatment using evidence-based, outpatient interventions in their homes. I firmly believe that one of the truest measures of the success of our children's mental health system will be how many children have recovered to the point of living at home, going to school and enjoying life as a child. Success will not occur with the expansion of hospital and residential programs alone, and it will never occur if kids languish in places that no longer meet their needs.

   Many of the new programs coming into the continuum are small, but a few of the new programs, particularly the specialty beds, are quite large, serving up to 40 children; they have the potential to become large boxes for waylaid children. This year, I have met far too many kids all across New Jersey who are slowly, painfully coming apart in settings that long ago stopped meeting their needs, including juvenile jails and psychiatric hospitals. We will be keeping a very close eye on the amount of time children spend in these new placements.

2. **Timing.** Brisbane is slated to close on December 31st, and the direct alternative programs – known as Intensive Residential Treatment Centers – are scheduled to begin caring for youth January 1st. The Department is confident that this transition can be accomplished smoothly, but the margin for error is zero. I offer a caution here that capacity building may stall unexpectedly and should continue to be monitored.

3. **New ground.** New Jersey has maintained a number of hospital-based, acute-care psychiatric stabilization settings, and one longer-term hospital-based psychiatric care setting. However, the new services being discussed today - new intermediate care, "intensive" residential treatment, "specialty" residential treatment, and "specialty" treatment homes – are in many ways new for the State of New Jersey. They imply the development of new levels of intensive psychiatric and behavioral health services for children. As these programs grow, and the clinical contours of each level of care become clearer, it will be important to have in place standards by which programs operate. Launching these programs, in other words, is just the beginning. They must be supported, monitored and continuously honed to best practice.

4. **We need a strong public-private collaboration.** As new services are created, the safety net for children will benefit from a strong degree of public accountability. For example, DHS has decided that clinical decisions about admissions to the Intensive Residential Treatment Centers will be made by a state clinical assessment team, not a private managed care entity. The development of public community-based and residential services would be a boon to this continuum too, since the need remains great as evidenced by the Department's needs assessment and the presence of so many children waiting for mental health services in juvenile jails and psychiatric hospitals.

5. **We need to ensure the prevention of abuse in these settings.** For many years, the Department was unable to timely investigate allegations of abuse or neglect of children in a variety of settings, including residential facilities. Over the past seven weeks, the Department has responded by cutting its backlog of institutional abuse investigations in half, which is very important. The new hospital and residential facilities we are discussing today will be serving vulnerable children with complex emotional disorders. Many of these children are at times lost to a darkness that saps their spirit and urges them to harm themselves or act out. Because of these children's acute needs and the fact that some of these programs practice the use of restraints, children can be hurt.

   My staff has reviewed the allegations of abuse or neglect of children within every program in the children's mental health system since January 1. We have also subpoenaed and reviewed the restraint logs of certain providers over the past year as well. Direct comparisons are complicated in part by the number of allegations which remain unresolved by the State, by the fact that programs are of varying sizes, and by the fact that some of these programs have simply not started serving children yet. But in general, the data indicates that residential mental health care for our children must be monitored aggressively.

There have been 17 allegations of abuse or neglect of children at Brisbane since January 1st, most of which remain under review by the Department's Institutional Abuse Investigation Unit (IAIU). Only six IAIU investigations of Brisbane have been completed, with half of these leading to substantiation of the allegation.

Among the private providers who will be offering expanded mental health residential services in the growing continuum, 10 have no history of abuse or neglect allegations this year. On the other hand, one agency has 25 allegations of abuse or neglect since January 1. Most of these allegations remain under investigation by IAIU, and none have been substantiated. Another provider has 17 allegations of record, one of which has been substantiated, three of which remain under review and 13 of which have been deemed unfounded by IAIU. A third organization has ten allegations, only two of which have been investigated and finalized – both unsubstantiated. Five more agencies have 6 to 9 allegations, most of which are still being investigated by IAIU. Because the system is about to grow rapidly, I urge the Department to monitor conditions in all these settings rigorously, and to ensure the prompt investigation of allegations.

6. **Out-of-state care is growing.** The shortage of mental health placements and services in New Jersey is a problem of long standing, and it has forced DHS to expand its utilization of out-of-state placements for children. Were it otherwise, hundreds more children would stay backed-up in psychiatric hospitals, juvenile jails and residential treatment centers. As of this month, there were 232 children placed in residential services outside of New Jersey. This number has grown significantly from January, when it was 196. For at least the next 12 months, DHS will further increase its universe of out-of-state placement options by sending up to 40 additional children to a newly-contracted Pennsylvania-based Residential Treatment Center. If there is any question about whether the continuum is adequately sized, the presence of children in out-of-state care settings shows the need remains great, and capacity building must continue.

7. **We must utilize these programs**. Simply building these programs does not mean the system will work. We need to ensure that all of the barriers to children accessing these programs are resolved. For example, we were recently advised by a provider advocacy association that most of the beds in an existing Residential Treatment Center usually sit empty because the organization has had difficulty navigating the Medicaid reimbursement system. Of course, barriers are not uncommon as new systems unfold. They must be overcome to ensure that the Department's ongoing efforts reap the expected dividends in the lives of our kids.

My intention, going forward, is to monitor the development of the new programs and services which are designed to replace Brisbane and establish a residential continuum of care. Our statute mandates that we review the investigations by

DHS of child abuse allegations. We will be paying close attention to the allegations and findings of critical incidents regarding the care of children in this new array of hospital, intensive and specialty residential services. My staff and I will be conducting site inspections at all of the new facilities as they come on line. We will be visiting some of these sites as early as this week.

All of you have been working hard for many years to improve the lives of New Jersey's children and families. Today, you have elevated the discussion of what will happen for children and adolescents in need of intensive mental and behavioral health services. The decisions we make in Trenton could well be the difference between a child's recovery or a sadder future punctuated by repeated hospitalization and despair.

Senator Vitale, I thank you for your leadership in bringing this important issue forward, and offer my thanks to the members of the committee for your continued concern for children.

Thank you.